PRINTED: 03/23/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
157474		B. WING			C 02/23/2015		
	NAME OF PROVIDER OR SUPPLIER  NIGHTINGALE HOME HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1036 S RANGELINE RD CARMEL, IN 46032	1 02	23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		G	000			
	This was a federal ho investigation.	ome health complaint					
		0 - Substantiated: No the allegation are cited. s are cited.					
	Survey date: Decemb 23, 2015.	er 29, 2014, and February					
	Facility number: 0098	554					
	Medicaid Number: 20	0107010					
	Ingrid Miller,	ak RN ASN					
	Current Census: 665						
G 111	January 6, 2	e Elder, MSN, BSN, RN 015 VTIALITY OF MEDICAL	G	111			
	The patient has the ric clinical records mainta	ght to confidentiality of the ained by the HHA.					
	Based on document agency failed to ensu	not met as evidenced by: review and observation, the re confidentiality of clinical y the home health agency ints.					
	Findings include:						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IN009554

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157474	B. WING		C 02/23/2015	
	NAME OF PROVIDER OR SUPPLIER  NIGHTINGALE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE  1036 S RANGELINE RD  CARMEL, IN 46032	02/23/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
G 111	Continued From pag		G 11	1		
	on 2/23/15 at 8:30 A Crown Point Nightin the desk at second confidential medical	ical information was observed M in an unlocked office at the gale office location. Inside observation (#3) were documents for patient #1 and se included information for e health agency.				
	address was located professional office by agency address on the front door, there names and floors of in the building. The observed on this significant elevator, located new To the left of the element immediately to the reglass door with the regulary	d inside a brick 3 story uilding. On arrival at the 2/23/15 at 8:30 AM, entering was a large sign with the the business entities located hospice name was not nage. Surveyor took the act to the sign, to the 3rd floor. vator was a corridor, and ight of the corridor was a name of another agency and tion listed as 8:30 AM - 4:30 and a phone number de the glass door was a tes. No one answered when ad on the door.				
	at 9:06 AM, surveyor 3rd floor for a second these suites was un in the complaint was way. The surveyor was no answer. The and asked if anyone answered. Inside to room, three individual a copy machine, and	ond observation. On 2/23/15 r #2 visited the office on the d time. The front door to locked. The suite mentioned s to the far right of the entry knocked on the door. There e surveyor opened the door was inside. No one nis office were a conference al offices, a kitchen area with d a storage room. One office and large L shaped desk and				

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	, ,	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  NIGHTINGALE HOME HEALTHCARE INC  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CATURE CONTINUED FROM THE APPROPRIATE DEFICIENCY)  (CATURE CONTINUE CONTINUED FROM THE APPROPRIATE DEFICIENCY)  (CATURE CONTINUE C			157474	B. WING			_	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					STREET ADDRESS, CITY, STATE, ZIP CODE  1036 S RANGELINE RD		02/23/2015	
file cabinet. Inside the file cabinet were two large lists of patients with the name of the Hospice as a header. One list was dated 2003 (Document A) and one was dated 12/3/14 (Document B) Inside the desk drawer were resumes of applicants for nursing and marketing positions and other documents C - F and H and J. Another office	PRÉFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
a letter from terminated employee C of the Ft. Wayne office (Document #1). The storage room was filled with medical supplies including syringes and blood specimin tubes. There was also a box with blank chart documents with the name of the Ft. Wayne hospice or the Ft. Wayne hospice phone number on the documents including document #G. (These documents including document #G. (These documents are explained fully in the complaint narrative for the hospice.)  4. An agency document titled "Information sheet" with the name of patient #1 scratched out but still legible included the patient's address, date of birth, diagnosis of liver cancer, Medicare number (scratched out but still legible), and other information about this patient. This document was found in the office desk drawer of the unlocked office. This is document #C listed above and in the complaint narrative.  5. On 2/23/15 at 11:45 AM, Employee A, registered nurse (RN), from the Ft. Wayne office via telephone call, indicated the Crown Point office should have been locked up to protect what had been left behind in the unattended office when the contents of the office were moved back to Ft. Wayne.	G 111	file cabinet. Inside a lists of patients with header. One list wa and one was dated the desk drawer we nursing and market documents C - F and contained a large be a letter from terminal Wayne office (Documus filled with mediand blood specimin with blank chart document #G. (The fully in the complaint 4. An agency document #G. (The fully in the complaint sinformation about the was found in the off unlocked office. The above and in the complaint sinformation about the was found in the complaint sinformation about the was found in the complaint was found in the off unlocked office. The above and in the complaint sinformation about the was found in the complaint was found in the complaint to the complaint was found in the complaint to file should have the had been left behind when the contents of the content	the file cabinet were two large the name of the Hospice as a as dated 2003 (Document A) 12/3/14 (Document B) Inside the resumes of applicants for ing positions and other and H and J. Another office tox with marketing material and the ated employee C of the Ft. Instant #I). The storage room cal supplies including syringes tubes. There was also a box cuments with the name of the for the Ft. Wayne hospice the documents including the accuments are explained at narrative for the hospice.)  Instant #I scratched out but still patient's address, date of the first address, date of the accument. This document fice desk drawer of the first is document #C listed to implaint narrative.  In the Hamber A, N), from the Ft. Wayne office the office were moved back the office were moved t	G 1	11			

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		157474	B. WING		_	C <b>02/23/2015</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	02/23/2013	
NIGHTING	ALE HOME HEALTH	CARE INC		CARMEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CIVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
G 111	received from the I Surveyor Supervis ESRD (End Stage (Rural Health Clinisurveyor #2 had end Crown Point and dincluded patient nature of the Current site which 7. At 1:16 pm, and received from Surveyor #2 send at 3:44 pm. The addisting patient named the surveyor #3 surveyor #4 send at 1:44 pm. The addisting patient named the surveyor years at 3:44 pm. The addisting patient named the surveyor #4 send at 1:45 pm. The addisting patient named the surveyor #4 send at 1:45 pm. The addisting patient named the signal home health agency facility (unknown with discharges/bereav care changes, receinterdisciplinary team the surveyor #2 send the signal home health agency facility (unknown with surveyor #4 send the surveyor #4 send the signal home health agency facility (unknown with surveyor #4 send the surve	At 10:30 AM, a phone call was PHNSS (Public Health Nurse or) for Home Health, Hospice, Renal Disease), and RHC c). The PHNSS indicated that intered a hospice facility in iscovered a client list which ames, diagnosis type, and was listed as 'IN NGHT HH." email with an attachment was veyor 2. The attachment en information that included a ew notes(?). It another email and attachment tachment was one sheet en, med record #, start of care ce, discipline, primary payer, also contained Comcast billing er resume with interview notes, Home Healthcare application atture of the administrator of the cy, an agenda for the hospice where) that listed ement, admissions, level of certifications due for todays am (IDT) meeting, and enext IDT meeting:  4, a third resume, billing and day off request with and hire date, and an offer alle home heatlth for the	G	1111			
	PHNSS that stated were of 1044 patie obscurity of who th Division Director] h in all complaints.	I, "Her [surveyor 2] records Ints and because of the Interest patient belong [sic] to [the Interest patient belong [sic] to [sic] the Interest patient belong [sic] to [sic] to [sic] the Interest patient belong [sic] to [sic					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONS		COMPLETED		
		157474	B. WING _			1	C / <b>23/2015</b>	
	NAME OF PROVIDER OR SUPPLIER  NIGHTINGALE HOME HEALTHCARE INC			1036 S F	ADDRESS, CITY, STATE, ZIP CODE RANGELINE RD EL, IN 46032	1 02	23/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
G 111	[home heatlh] and Hh an email dated Febru surveyor 3 indicated t	e 4 HP [hospice] of Carmel." In ary 26, 2015, at 10:55 AM, the PHNSS indicated the tain the confidentiality of the	G ·	111				
G 239	, ,	ation is safeguarded against	G 2	39				
	Based on document safeguard clinical rec	not met as evidenced by: review the agency failed to ord information against loss or a total of 1044 clients.						
	Findings include:							
	on 2/23/15 at 8:30 AN Crown Point Nighting the desk at second of confidential medical of	locuments for patient #1 and e included information for						
	address was located professional office bu agency address on 20 the front door, there we names and floors of the in the building. The hobserved on this sign elevator, located next To the left of the elevation immediately to the rig	observation. The agency inside a brick 3 story ilding. On arrival at the /23/15 at 8:30 AM, entering was a large sign with the he business entities located rospice name was not age. Surveyor took the ato the sign, to the 3rd floor. The ator was a corridor, and ht of the corridor was a ame of another agency and						

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G 239	Continued From page	ge 5	G 2	39			
	daily hours of opera PM Monday-Friday 2 219-310-8537. Insichallway with two suithe surveyor knocked 3. This was the second 19:06 AM, surveyor 3rd floor for a second these suites was un in the complaint was way. The surveyor was no answer. The and asked if anyone answered. Inside the room, three individual a copy machine, and had a fax machine a file cabinet. Inside the lists of patients with header. One list was and one was dated the desk drawer well nursing and marketing documents C - F and contained a large board a letter from terminal Wayne office (Documents Mayne office (Documents Mayne office) and blood specimin	tion listed as 8:30 AM - 4:30 and a phone number de the glass door was a tes. No one answered when do on the door.  Indicate the office on the dime. The front door to locked. The suite mentioned is to the far right of the entry knocked on the door. There is surveyor opened the door was inside. No one his office were a conference all offices, a kitchen area with do a storage room. One office and large L shaped desk and the file cabinet were two large the name of the Hospice as a stated 2003 (Document A) 12/3/14 (Document B) Inside the resumes of applicants for applicants for any positions and other downwith the marketing material and the demployee C of the Ft. The ment #I). The storage room call supplies including syringes tubes. There was also a box					
	Ft. Wayne hospice of phone number on the document #G. (The fully in the complain 4. An agency document the name of particular in the same of particu	uments with the name of the or the Ft. Wayne hospice the documents including se documents are explained to the narrative for the hospice.)  ment titled "Information sheet" tient #1 scratched out but still patient's address, date of					

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		B. WING			C <b>02/23/2015</b>		
NAME OF P	ROVIDER OR SUPPLIER	10.1.1		STREET ADDRESS, CITY	/, STATE, ZIP CODE	02/23/2013	
NIGHTINGALE HOME HEALTHCARE INC			1036 S RANGELINE RD CARMEL, IN 46032	)			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 239	birth, diagnosis of lives (scratched out but so information about the was found in the offunlocked office. The above and in the contents of th	ver cancer, Medicare number till legible), and other is patient. This document ice desk drawer of the is is document #C listed is is document #C listed implaint narrative.  :45 AM, Employee A, N), from the Ft. Wayne office indicated the Crown Point icen locked up to protect what id in the unattended office if the office were moved back in the office were moved back in the unattended office in the office were moved back in the unattended office in the office were moved back in the o	G	239			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER  NIGHTINGALE HOME HEALTHCARE INC			1036	ET ADDRESS, CITY, STATE, ZIP CODE  S RANGELINE RD  MEL, IN 46032	021	02/23/2013	
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G 239	facility (unknown wischarges/bereaw care changes, receinterdisciplinary tea Recertifications du Wednesday 12/3/1 information, persor employee 's name letter from nighting Masters of social wighter from 1044 patie obscurity of who the Division Director in all complaints. The you) [unknown] this [home heatth] and an email dated Februrveyor 3 indicates	ey, an agenda for the hospice there) that listed tement, admissions, level of tertifications due for todays am (IDT) meeting, and the next IDT meeting:  4, a third resume, billing that has off request with the and hire date, and an offer alle home heatlth for the	G	239				